CONNECT HEALTH + WELLNESS

School Based Health Center

STUDENT'S NAME: _____ _____ _____
Gender Identity ☐ Male ☐ Female ☐ DECLINE to Specify — Student Date of Birth — Grade

Students Class: _____ Student's School: _____

_____ _____ _____ _____
Mailing Address — City — State — Zip Code

Race (check all that apply):☐ Black/African American ☐ White ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Japanese ☐DECLINE
Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ DECLINED to specify. **Preferred Language**: ☐ English ☐ Spanish ☐ Other: _____
Accessibility Needs: ☐ Hearing Impaired ☐ Vision Impaired ☐ None **Interpreter Needed**: ☐ Yes ☐ No
Allergies: _____ **Pharmacy** _____

PARENTS/LEGAL GUARDIANS

Lives with ☐ Father ☐ Mother ☐ Both ☐ Other: _____

Parent or Legal Guardian Name | Phone# (Home or Cell) | Phone # (Work) | Email Address

Parent or Legal Guardian Name | Phone# (Home or Cell) | Phone # (Work) | Email Address

How do you prefer to be contacted? ☐ Mail ☐ Phone ☐ Email ☐ In person

EMERGENCY CONTACT

Name — Relationship to Student

Address — City — State — Zip

( ) Phone: Home ( ) Phone: Cell ( ) Phone: Work

I authorize Connect Health + Wellness School-Based Health Care to leave messages related to my care via answering machine/voicemail. ☐Yes ☐ No

GUARANTOR/RESPONSIBLE PARTY (REQUIRED)

Name_____ Phone#_____

Relationship to student: _____ Birthdate of Guarantor: _____

Address — City — State — Zip

Is this Guarantor also a patient enrolled in other Connect Health + Wellness services? ☐ Yes ☐ No

INSURANCE INFORMATION

☐ **HEALTH INSURANCE** (Private insurance, Medicaid, ID Number/Policy Number, etc.) ☐ **NO HEALTH INSURANCE**
Check one: ☐ **My family WILL apply for the sliding fee discount** ☐ **My family DECLINES the sliding fee discount**

Name of Insured: _____ Relationship to Patient_____ Birthday of Insured: _____

PRIMARY Insurance Company — ID/Policy Number — Group Number
Do you have prescription coverage? ☐ **Yes** ☐ **No**

Name of Insured: _____ Relationship to Patient_____ Birthday of Insured: _____

SECONDARY Insurance Company — ID/Policy Number — Group Number
Do you have prescription coverage? ☐ **Yes** ☐ **No**

HEALTH INFORMATION

Doctor's Name_____ Current Medications _____

Please place an x for the following services you would like your child to have during the current school year in School-Based Health Care:

☐Medical ☐Dental ☐Behavioral Health ☐Optometry/Vision

CONSENT FOR OVER-THE-COUNTER MEDICATIONS

No over-the-counter medications (OTC) will be given to a child who does not have a registration/consent on file for the current school year. I grant permission for the Connect Health + Wellness (CHW) School-Based Health Care clinical staff to administer the OTC medication selected below to my child as he/she requests. I and my child understand that a total of only three OTC medications will be administered during one school year. Frequent requests for OTC medications could suggest the need for an examination by a healthcare provider. ☐ Yes ☐ No

These are the OTC medications we may administer:

☐Ibuprofen ☐Tylenol ☐Benadryl ☐None

NOTICE OF PRIVACY PRACTICE/PARENTAL CONSENT

Connect Health + Wellness (CHW) Notice of Privacy Practices is posted at the School-Based Health Care Center. I may obtain a Notice of Privacy Practice by contacting CHW at (276) 638-0787 or emailing info@connecthealthva.org or by pasting this link in my browser: https://connecthealthva.org/privacy-practices-notice. The Notice of Privacy Practices (Notice) provides information about how CHW may use and disclose protected health information about the student/patient. As the student's guardian, I have a right to receive and review the Notice before signing this acknowledgment. As provided in the Notice, the terms of the Notice may change. If the Notice is changed, I may obtain a revised copy.

By signing this form: I acknowledge that I have been informed of the uses and disclosures of protected health information about my child for all the purposes set out in the Notice. I acknowledge that I have reviewed the Notice, understand the contents of the Notice and how it applies to my child, and that all my questions regarding the contents of the Notice have been answered. I also understand that I may revoke the permission for disclosure of protected health information at any time by contacting CHW at (276) 638-0787 or emailing info@connecthealthva.org, in writing. If I revoke my permission, CHW will no longer use or disclose protected health information about my child for the reasons covered by my authorization.

All services (excluding first aid) provided at the CHW School-Based Health Care Center require consent of the student's parent or guardian. I understand those services may include nursing care, medical treatment, dental care, vision care, referral for counseling, and other health care services to promote my student's health; and that all healthcare information is confidential. **By signing this form, I, the parent/guardian of said student, give consent for him/her to receive health services.**

Guarantee of Payment & Pre-Certification: In consideration of the services provided by CHW, I agree that the Guarantor is responsible for all charges for services received which are not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I agree to pay all said charges. I further agree that, to the extent permitted by law, I will reimburse CHW for all costs, expenses and attorney's fees incurred to collect those charges. If my insurance has a pre-certification or authorization requirement, I understand that it is my responsibility to obtain authorization for services rendered according to the plan's provisions. I understand that my failure to do so may result in reduction or denial of benefit payments and that I will be responsible for all balances due.

By submitting (signing) this consent form:

(1) I am authorizing my child to receive services from CHW and its providers when I am not present;
(2) I agree to accept the risks of medical procedures, medication(s), testing (including HIV), and other treatments and services provided by CHW;
(3) I agree to abide by the CHW procedures and patient responsibilities set out in this form;
(4) I grant CHW permission to bill my child's insurance for services provided.

I acknowledge that I have read this form or had this form read and explained to me, that I understand it and agree to its content. I agree to be truthful in providing information.

Scan for more info on Sliding Fee Discount Program.

https://connecthealthva.org/sliding-fee-program

Print Parent/Guardian Name **Date**

Signature of Parent/Guardian **Date**

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